DPHHS-SLTC-146
(Rev. 01/16)

STATE OF MONTANA
Department of Public Health and Human Services

HOME AND COMMUNITY BASED SERVICES
WAITING LIST CRITERIA TOOL

Applicant: _____   Slot Category: _____

Social Security Number: _____   Review date: _____

			Date _____	Date _____	Date _____
1. Is the applicant at risk of medical deterioration without services?	No	Yes	1 2 3	1 2 3	1 2 3
2. Does the applicant have cognitive impairment?	No	Yes	1 2 3	1 2 3	1 2 3
3. Is applicant currently in a nursing facility or at risk of institutional placement or death?	No	Yes	1 2 3	1 2 3	1 2 3
4. Does the applicant require 24-hour supervision?	No	Yes	1 2 3	1 2 3	1 2 3
5. Is there a need for more formal (paid) services?	No	Yes	1 2 3	1 2 3	1 2 3
6. Are the existing supports (informal) sufficient at this time?	No	Yes	1 2 3	1 2 3	1 2 3
7. Does the primary caregiver need relief?	No	Yes	1 2 3	1 2 3	1 2 3
8. Is there a need for adaptive aids or environmental modifications?	No	Yes	1 2 3	1 2 3	1 2 3
9. Are there other health and safety issues (Not identified in 1-8) that place the applicant at risk? Please explain below in comments.	No	Yes	1 2 3	1 2 3	1 2 3
10. Does the applicant require spousal impoverishment or waiver of deeming for children, to qualify for HCBS?	No	Yes			

Total Score: _____

Comments: _____

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_____

CMT Signature: _____   Date: _____